NAVAL WAR COLLEGE
Newport, R.I.

THE JOINT MEDICAL COMMAND: BOON OR BANE FOR THE SUPPORTED CINC?

by

Paul E. Casinelli
Colonel, CTARNG

A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Joint Military Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy.

Signature: _____

18 May 2001

_____
Colonel Patrick Sweeney, USA
Professor, JMO Department

_____
Captain Robert Miller, Jr., USN
Professor, NWDC

Report Documentation Page

Report Date	Report Type	Dates Covered (from... to)
18052001	N/A	-

Title and Subtitle The Joint Medical Command: Boon or Bane for the Supported CINC?	**Contract Number**
	Grant Number
	Program Element Number
Author(s) Casinelli, Paul E.	**Project Number**
	Task Number
	Work Unit Number
Performing Organization Name(s) and Address(es) Naval War College 686 Cushing Road Newport, RI 02841-1207	**Performing Organization Report Number**
Sponsoring/Monitoring Agency Name(s) and Address(es)	**Sponsor/Monitor's Acronym(s)**
	Sponsor/Monitor's Report Number(s)
Distribution/Availability Statement Approved for public release, distribution unlimited	
Supplementary Notes	
Abstract	
Subject Terms	
Report Classification unclassified	**Classification of this page** unclassified
Classification of Abstract unclassified	**Limitation of Abstract** UU
Number of Pages 22	

REPORT DOCUMENTATION PAGE

1. Report Security Classification: UNCLASSIFIED

2. Security Classification Authority:

3. Declassification/Downgrading Schedule:

4. Distribution/Availability of Report: DISTRIBUTION STATEMENT A: APPROVED FOR PUBLIC RELEASE; DISTRIBUTION IS UNLIMITED.

5. Name of Performing Organization:
JOINT MILITARY OPERATIONS DEPARTMENT

6. Office Symbol: C	**7. Address**: NAVAL WAR COLLEGE 686 CUSHING ROAD NEWPORT, RI 02841-1207

8. Title (Include Security Classification):
The Joint Medical Command: Boon or Bane for the Supported CINC?

9. Personal Authors: Paul E. Casinelli. M.D. COL MC CTARNG

10.Type of Report: FINAL	**11. Date of Report**: 18 May 2001

12.Page Count: 22 **12A Paper Advisor (if any):Captain Robert Miller, USN, Colonel Patrick Sweeney, USA**

13.Supplementary Notation: A paper submitted to the Faculty of the NWC in partial satisfaction of the requirements of the JMO Department. The contents of this paper reflect my own personal views and are not necessarily endorsed by the NWC or the Department of the Navy.

14. Ten key words that relate to your paper: Joint Medical Command, Health Service Support, Military Medicine, Operational Medicine, Combat Health Service Support, Joint Health Service Support

15.Abstract:

The intent of this paper is to demonstrate that the key to operational medical readiness of the Department of Defense is to inaugurate a joint USMEDCOM. This new CINCdom should be modeled after the USTRANSCOM and USSOCOM examples, a functional, supporting CINCdom. Arguments are presented that counter those previously used to defeat such a proposal. Indispensable to the success of such an undertaking is the requirement that such an enterprise be a truly Joint endeavor whose primary effort is to plan and train for operational (field) health service support across the spectrum of the Department of Defense.

16.Distribution / Availability of Abstract:	**Unclassified** X	**Same As Rpt**	**DTIC Users**

17.Abstract Security Classification: UNCLASSIFIED

18.Name of Responsible Individual: CHAIRMAN, JOINT MILITARY OPERATIONS DEPARTMENT

19.Telephone: 841-6461	**20.Office Symbol: C**

Security Classification of This Page Unclassified

Proposals supporting the desirability of a Department of Defense unified Medical Command are not new. Their focus, however, has not been on its validity in relation to its impact on the Geographic Commands, but on the individual Services, and the Department of Defense as a whole.[1] This paper argues that the establishment of a Department of Defense Joint Medical Command would be a boon to the Geographic Commander in Chief (CINC) as well as the Joint Task Force Commander (JTFC). Specific instances where this is demonstrated will be proffered. A detailed description of the organizational and force structure of such a command will not be advanced as that is beyond the scope of this study.

Immediately after World War II there began a number of attempts to consolidate the health care and medical operations of the individual Services.[2] In 1947, Eisenhower, as Army Chief of Staff, recommended a unified medical service.[3] Most of the early attempts were aimed at increasing overall operational medical capability by streamlining seemingly redundant field medical services, equipment, and procedures. Later attempts focused more on reducing costs, but highlighted the rapidly expanding "mission" of retiree and dependent health care (DHC).[4] Only in the last two decades, and especially after Desert Shield/Storm, has there been a major effort to consolidate the Health Services Support (HSS) of the independent Services for the purposes of increasing operational medical readiness through greater interoperability and jointly planned and executed medical support.[5] Even with this new direction, however, the greater concern remained cost savings for DHC.[6]

The first study since Eisenhower's that advanced what appears to be the most useful proposal impacting directly on the issue of medical readiness, and therefore on the capabilities of a supported CINC, was a 1982 Senate Armed Services Committee directed Office of the Secretary of Defense report which concluded that the establishment of a Defense Health Agency

(DHA) was not only feasible, but desirable.[7] It was anticipated to both cut military health care costs and improve wartime readiness.[8] The DHA was envisioned to be a tri-service organization created to manage all DoD health care "..under all conditions of peace and war."[9] It would integrate all fixed facility medical care with the [then] CHAMPUS program, and the Director would be the medical advisor to the Joint Chiefs of Staff (JCS).[10] In spite of its promise, this proposal was rejected by the JCS for a number of reasons. One reason was that the loss of operational control of the HSS assets within each individual Service would actually decrease operational medical readiness. A second major objection was that the abolition of Service identity would create morale problems among the medical personnel (and, one is led to believe, among the personnel of the Services themselves).[11] A third reason was that the sheer size and scope of such an activity would be so great as to actually *increase* the management problems instead of alleviate them.[12] These are serious concerns voiced by the JCS that directly impact on both the wartime and peacetime capabilities of a supported CINC or operational commander.

A 1992 Defense Review Initiative of the DHA concept restated support for it. Once again non-concurrence from the Joint Staff as well as the from individual Services was evoked, this time on the basis of loss of operational control of the medical assets.[13] The concern at that time was that a bureaucracy that had neither regard for, nor understanding of, the supported CINCs' priorities would have control of assets vital to the CINCs' missions.[14] Even the Assistant Secretary of Defense for Health Affairs (ASD-HA) non-concurred, claiming that coordination of efforts rather than consolidation was the answer to both readiness and cost containment.[15]

Prior to the 1992 Review, the ASD-HA tried to create a medical Planning, Programming, and Budgeting System (PPBS).[16] The intention was to allow the ASD-HA to have a greater

voice in medical resource planning and definitive authority over all DoD medical programs. It was felt that there would be less redundancy of effort, and therefore less waste, if one agency controlled the medical effort of the three Services. This proposal was solidly opposed by the Joint Staff, the CINCs, and the Services as a departure from a process that was designed to allow senior service leadership to balance the total budgeting effort to maximize the CINCs in their roles.[17]

Finally, in 1991, the Cooke Study proposed three different means of achieving medical resource management by one organization or individual. The three proposals were: "a. A unified medical budget under ASD(HA), similar to the 1986 [ASD(HA) proposal to create Medical PPBS] effort; b. A US Medical Command; c. A DHA, similar to the FY92 DMR initiative [see above]."[18] The study was uniformly rejected by the Chief, JCS and the Services, perhaps because it "…did not address the impact on CINCs' authority over intra-theater medical support and the ability to support combat operations."[19]

In reviewing the literature, it is evident that there is a long history of attempts to consolidate the medical support of the Department of Defense. In each case, the proposal was soundly rejected. The reasons varyied from adverse affects on morale and the unique needs of each service, to the sheer magnitude of the effort or the adverse impact it was projected to have upon the CINCs' missions due to loss of control over such a critical asset.[20] Of all of the reasons for non-concurrence of the separate agencies, the most valid and disquieting is the possible negative impact upon the CINCs' missions.

Only in the Cooke study, listed above, was the proposal of a "US Medical Command" advanced by a government agency.[21] The Eisenhower suggestion of a Unified Medical *Service* in the mid 1940's was brushed aside at that time as impractical.[22] It was a "Purple Suit" concept

that took all control of medical support away from each Service, and was heartily resisted by the Services.[23] Unfortunately, in the Cooke proposal, there was no clear argument made as to how such a separate command would be a boon to the CINC in the successful accomplishment of his mission.[24] Such argument will now be proffered. In the course of arguing for the positive impact such a functional CINCdom would have on the Combatant Commander's mission, the more trivial arguments to the opposite will first be addressed.

The first argument against a Joint Medical Command (USMEDCOM) always seems to be Service uniqueness.[25] All the Services echo the common theme that each Service is unique and therefore has special needs because of its role, mission, or the environment in which it performs that mission. To a great extent, this is a valid argument, but only on the tactical level. This objection ceases to be valid at the operational level.[26] While there is a vast difference in delivering health care in a fixed medical treatment facility (MTF) versus in a Battalion Aid Station (BAS), or in practicing Diving Medicine versus being part of an Airborne Forward Surgical Team (FST), the operational and higher levels of Military Medicine are the same across the services. A Theater Army (TA) Surgeon, for example, is a special staff officer to the (TA) Commander. As such, "…he is responsible to the TA commander for staff planning, coordinating, and developing policies for the HSS of TA forces."[27] He also normally is the Commander of the MEDCOM, one of the mission-oriented organizations "owned" by the TA Commander.[28] He also has no assigned clinical duties. To continue the example, the Army's Corps Surgeon is also a special staff officer, also without any assigned clinical duties. He enjoys direct access to the Corps Commander concerning HSS. Unlike the TA Surgeon, he usually has no command authority and coordination with both higher and lower HSS levels is done through unit command channels.[29] The main mission of both Surgeons is to advise the Commander as to

the medical threat, the methods of addressing it, and promoting those actions that best preserve the health of the command, in order to "Conserve the Fighting Strength."[30] This is a Theater-wide consideration that while "fought" on a tactical level, is planned and provided for on operational and strategic levels. According to Joint Pub 4-02, "Geographic Combatant Commanders are responsible for coordinating and integrating HSS within their theaters. *Where practical* [emphasis added] joint use of available medical assets will be accomplished…A joint force surgeon (JFS) should be appointed…."[31] It would appear that if a locally and temporarily appointed Joint Force Surgeon is considered the ideal solution to unify the medical forces in theater to most expeditiously accomplish the medical mission, then it would appear that at the CINC level, a Commander, USMEDCOM would best direct the joint effort DoD-wide. If a JFS can or should be appointed by a JFC, then it should follow that using "Service uniqueness" as an argument for keeping military medicine or HSS separated by Service on an operational or strategic level is as preposterous as saying that each Service still needs to fight its own battles without regard for the synchronization, economy of force, and mass afforded by fighting as a joint entity. Another reason the "Service uniqueness" argument is invalid is that a truly Joint MEDCOM is *not* the "Purple Suit" organization that was suggested in the DHA proposal. Just like USSOCOM and USTRANSCOM, the Joint USMEDCOM is just that, *JOINT*. It would be a legitimate CINCdom, functioning just like the successful USTRANSCOM, being a supporting command to all CINCs. Its body would be made up of the medical personnel of its respective Service components, each organized as its own subordinate command within the MEDCOM. It is a management organization operating on a CINC-to-CINC level. The point being that at the tactical level (and according to Army FM 8-10 that means as far up as the Corps) there still is the camaraderie and esprit of "Service uniqueness."[32] Much like the USSOCOM, there would

continue to be promotion within the parent Service based on merit, while professional education, experience, and relationships develop the medical department individual into an increasingly responsible, competent, and valuable asset not only as part of the parent Service, but also in joint endeavors. If anything, morale would be strengthened, retention would be enhanced, and at the grass roots level, the CINCs' capabilities would be magnified. In support of the argument that "service uniqueness" would not suffer, it is appropriate to mention here that the individual Services would still retain all Title 10 responsibility for the personnel assigned to the MEDCOM. As far as troop morale in general is concerned, one should be able to appreciate that if those that serve you are in a high state of morale, the services they provide are of better quality and are delivered in a more effective manner, therefore increasing the morale of those served. Morale is a winner all the way around, a subtle, yet important combat multiplier.

The next criticism of a centralized agency for Health Service Support of the Armed Forces is that it would be too large and ultimately unmanageable.[33] As health care is arranged now it *would* be unmanageable. The key here is that one cannot just tie the medical departments of all the Services together in a new joint headquarters and say that the problem is fixed. The whole objective is to streamline the existing system to make it more responsive to the CINC, not just provide more oversight and a few more "flag billets."[34] How does this help the Combatant Commander? It does so in several ways.

The first way in which the creation of a (Joint) USMEDCOM helps a Geographic CINC is to remove all manner of inter-service administrative impedimenta that bogs down requests for support. The supported CINC wouldn't have to go through the several levels of command and administration through the Service chiefs down to the medical departments of who knows *which* medical department, just to find out if support of the kind he needs *might* be available, either

right now or in the future for planning purposes, let alone trying to actually get names and faces assembled and en-route to his area of need, as well as spending time figuring out who's paying for it. If there were a CINCMEDCOM, who had DoD-wide control and knowledge of such assets, the finding and deploying of those assets would be, figuratively speaking, "a done deal with a handshake." While nothing is quite that easy, the system would be much more responsive than it is now. The professional, centralized source would have both the oversight and the insight to further balance and enhance the package from across the depth of the services providing a tailor-made solution for the supported CINC based on the mission requirements. Also, with complete control of the assets, it is much easier and quicker to prioritize the requests coming from the various CINCs.

By now the reader has no doubt noticed that the focus has been on *operational (field) medical care*, and very little has been said about peacetime retiree and DHC. This is another way to avoid an entirely unwieldy organization. The USMEDCOM would be geared to the training for and delivery of operational HSS as its primary mission. Retiree and DHC would be handled by a component of the USMEDCOM, but only insofar as arranging for contract services by established health care organizations. In this way, not only can there be cost savings because of volume bargaining, but the contracts would be reviewed by one agency instead of several across the DoD. Once again, standardization of plans, care, and negotiation not only will allow for a streamlining in personnel across all the Services, but should also increase quality of life for both the service member and his/her dependents, creating a higher retention rate of experienced personnel. The Active Duty medical practitioner/HSS Commander can turn his/her attention full time to training and planning for deployment and HSS under field conditions, truly practicing

"Military Medicine" instead of merely practicing medicine in the Military.[35] The supported CINC can be seen only to gain from such a situation.

One of the reasons cited for the lack of operational medical readiness in today's forces is the emphasis that was placed on retiree and DHC as mentioned above. It actually grew out of a need to train and have on hand a large number of medical specialists and allied health care personnel in case of armed conflict with the USSR.[36] In order to justify the numbers of hospital beds and medical personnel, DHC became routine as a training vehicle and as a justification for the "standing army" of those personnel. Over time, this emphasis led to the abandonment of operational (field) medical training as a legitimate requirement for the hospital based personnel.[37] The reigning theory at that time was that the everyday "practice of Medicine in the Military" was the best training for those personnel, and that "field training" not only was a waste of their talents, but in reality would degrade them.[38] The practice of Military Medicine gave way to practicing Medicine in the Military. The USMEDCOM would reverse this picture.

The next argument in favor of a CINC-level USMEDCOM is one of standardization. In this area there is already a great foundation. One can start with the primary objective of Health Service Support that is the same across the Services, and ascribed to in Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations. That objective is to conserve the fighting strength. Further in that paragraph it states that this is best "…achieved through optimum use and integration of available component command HSS assets."[39] This is even more efficiently and effectively accomplished if the Combatant Commander, through the supporting CINCMEDCOM, has easy access to DoD-wide assets. Again quoting Joint Pub 4-02, "Effective HSS enhances the combat strength of the joint force…."[40] This is accomplished by applying principles and levels of care common to all the Services. This commonality of mission objective

and approach, along with the universally accepted standard of care, has already laid the groundwork for standardization of HSS across all the medical CINCdom.

Ironically, while in general, medical care and equipment seems pretty much the same, it is not *standard*. And this is true not only between the Services, but also between hospitals in the civilian world. The types of equipment, in whatever configuration they are packaged, and at what levels of care they are distributed, may not be the same in each Service. For ease of logistical support and medical planning a centralized DoD authority should implement such standardization. Not that this would be accomplished without Service resistance. Each Service would claim specificity of mission and mission environment as justification for its own preference in equipment. Some compromise would undoubtedly be made as well as some occasional allowances for user-specific equipment justified by easily defensible argument. The point is that a centralized body responsible for planning and acquisition would be "calling the shots." This would not only increase the flexibility of HSS, but also decrease response time, cost, and size of the logistics tail, to include maintenance requirements. Also, in this way assets from one area of the CINC's Theater of Operations or even from another Theater can be used to supplement that CINC’s HSS elements and immediately be effective, without any need for equipment familiarization or reworking. An example of this is the Army system of Modular Medical Support. All levels of care are built out of common standard “building blocks” or modules. Support packages of increasing capability are built out of combinations of these modules to fit the medical mission. Should a module be destroyed, lost, or depleted, another of the same module can be sent to replace it (this includes the personnel who man the module).

The same pertains to standardization of policy and procedures. With standardized training and procedures all HSS personnel would know how to handle all administrative actions

and all procedures from road marches to theater medical evacuation, no matter to which Service component medical unit they were assigned.

This, of course, would directly link into complete interoperability. A serious problem encountered during Desert Shield/Storm was the incompatibility of radios in the MEDEVAC helicopters of the Reserve units.[41] There were a number of other problems of the same nature, but this alone could have been a "war stopper" as far as medical support was concerned. Before one cries out that this was an intra-Service problem, and therefore not joint, it must be remembered that MEDEVAC is essentially a shared asset across the whole theater, and those helicopters could end up supporting any of the forces within it, even ferrying casualties to the off-shore Naval medical facilities (if the pilots are qualified for that endeavor, another argument for joint training). All equipment would be budgeted for and bought by the USMEDCOM, much the same as USSOCOM procures its own equipment from its own independently submitted budget. Contrary to the concerns voiced against the 1986 ASD proposal for a separate medical PPBS, this idea of a separate USMEDCOM budget would not only aid in the standardization of equipment, but overall it would increase the capability of the supported CINCs through increased agility, flexibility, and speed of response, not to mention an ultimately decreased logistics tail. As it is, medical has its own separate class of supply (Class VIII) specifically to avoid the long lag times inherent in the normal supply system.

As far as policy and procurement are concerned, a USMEDCOM that spans the DoD and is involved in the higher levels of strategic planning with its own budget would be more pro-active in developing USMEDCOM plans and equipment most likely to be in synch with the DoD near term and future visions. It would therefore be able to more efficiently and effectively support a geographic CINC. By this is meant not only keeping a greater percentage of his people

in theater and therefore truly being a force multiplier, but also in matching the communications and movement strategies and capabilities of the supported Commanders.

One more area in which a USMEDCOM would be a boon to a supported CINC is in the seamless integration of the Reserve medical forces into the active component. Time and again, forces have gone to the field and exercises have been cut short or cancelled because active duty medical personnel could not be spared from clinic duties to go to train with their "go to war" units.[42] In instances where the medical personnel *have* gone to the field, MTF commanders have had to cut services until they returned.[43] This not only infuriates the dependents and retirees that think they have a *right* to military health care, but it also cuts care to the remaining active duty troops, thereby cutting into the reserve the CINC thought he had available to him.

If there were a CINC that had oversight of all Service medical components, including the Reserves, he could better coordinate Reserve Active Duty for Training (ADT) or Active Duty for Special Work (ADSW) to be synchronized with the Active Force training schedules. With the depth of personnel available to him, the appropriate mix of personnel, or "package" would be assembled, whether it be for routine backfill or even to complement the Theater Engagement Plan developing good will through medical operations. In fact, in this time of increasing reliance on host nation and allied support, a coordinated system of medical readiness exercises is an excellent way the supported CINC can not only build good will in his theater, but can actually improve the level of medical readiness of our allies in his area. This was the case in Cameroon where a joint (Army and Air Force) mass casualty exercise was held.[44] One important benefit from that exercise was the marked improvement of interoperability not only among the military elements, but also between the military and host nation medical establishment. A joint USMEDCOM can more effectively and efficiently organize such events for the supported CINC.

Especially regarding casualty care, the better trained both US and allied health care providers are, the quicker the wounded are treated and the higher the percentage of Returns to Duty (RTD). This is yet more evidence of properly directed military medicine being an effective combat force multiplier for the CINC.

Engagement through military-to-military training and education is a significant tool in the CINC's Theater Engagement Plan (TEP). Properly coordinated medical missions in both the civilian and military sectors, executed within the construct of the TEP, will greatly improve the scope and effectiveness of the CINC's TEP. Medical Civil Assistance Programs (MEDCAPs) and Medical Readiness Training Exercises (MEDRETEs) are just two of the many vehicles the CINC has to provide Humanitarian assistance within the command.[45] In using this powerful implement, however, the CINC must insure that it complements programs already in progress under the auspices of the Department of State (which normally has ownership of these activities).[46] Also, a past problem has been the abandonment of routine medical services within the command when professionals were diverted from those daily duties to perform the Humanitarian Assistance mission.[47] Again, a central medical manager would better coordinate such activities because of the level at which such interagency coordination may be effected, as well as the pro-active role the CINCMEDCOM will have in supporting the CINC's TEP.

Before concluding, the reasons of the ASD-HA for his non-concurrence with the findings of the 1992 DRI will now be addressed. The ASD-HA claimed that coordination of effort, rather than consolidation of assets (in a DHA) was all that was needed to improve HSS.[48] He also expressed concern over his belief that the DHA would be a bureaucracy that would not understand the CINCs' priorities, and would have no regard for them.[49] If one approaches this from the standpoint of a joint USMEDCOM effort, considering the above discussion, that

reasoning is flawed. The CINC, USMEDCOM would lead a seamlessly coordinated effort under a single command with a single purpose. It would not exist as a feigned and flawed superficial and tenuous coordination marred by inter-service rivalries and agendas. The single command of such assets adheres to the principle of Unity of Command, which "…requires a single commander with the *requisite authority* to direct all forces in pursuit of a unified purpose."[50] That command arrangement would also adhere to the sub-principle of Unity of Effort, where the medical effort would then be part of a collateral effort supporting the CINC's main force operations toward a common objective. All efforts of the USMEDCOM would be tailored to the specific needs and goals of the supported CINC, assured by coordination *on the CINC level* between the supporting and supported commands. So, one can see that contrary to the ASD-HA's concerns, the consolidation of HSS under one CINC would allow for a *greater* understanding of the supported CINC's priorities, and would not be the unwieldy bureaucracy that he envisioned.

In addition, under one Commander, and with the primary objective of delivering field HSS, the USMEDCOM can jointly train to be efficient and effective in carrying out the roles and functions that are the essence of its charter.[51] Those functions are what make Military Medicine the combat multiplier it is for the CINC. They are separately considered for ease of enumeration and specificity in training, yet each builds upon and supports the other, and they must be integrated and synchronized across the Theater. The role of Medical Command is the centerpiece of them all, and through it is achieved the economy of forces and unity of effort that gives the CINC an effective "medical weapon." And it *is* a weapon in the fact that through the roles of Preventive Medicine, and Troop medical care, needless non-battle casualties are prevented; through the roles of sound medical planning and advice, transport of the sick and

wounded is made more efficient and combat casualty care is more successful in returning more soldiers to duty in theater instead of their being lost to the CINC; medical logistics is streamlined to enhance the capability of the medical personnel to accomplish the above.

In conclusion, it is readily apparent that the establishment of a jointly organized USMEDCOM, with its own separately submitted budget, modeled after the USSOCOM and USTRANSCOM successes, is the answer to the problem that has been evidenced with operational medical readiness. A functional joint command organized under one supporting CINC that deals at the same level as the supported CINCS, USMEDCOM will have the depth, flexibility and agility to support the Combatant Commander to a degree not yet attained. It will accomplish this through its adherence to the principles of Unity of Command and Effort and Economy of Force. Adhering to these principles, and training and functioning as a joint entity, primarily dedicated to the Health Service Support of the supported CINCs, USMEDCOM will be a BOON to the supported CINC, enhancing his capabilities not only in all levels of conflict, but also in peace, helping him in shaping the Theater in support of the Nation's Security Strategy.

ENDNOTES

[1] Richard Hunter, Report for the Secretary of Defense on the Feasibility and Benefits to be gained from Creating the Defense Health Agency, (Arlington, VA: SRA, 1983), ES-1. See also, Michael Brennan, "Military Medicine for the Twenty-First Century: To Shape the Future" (Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1992), 26, and Directorate for Organizational and Management Planning, Review of the Department of Defense Organization for Health Care, (Washington, DC: 1991).

[2] David Wehrly, "Military Medicine Focused for Joint Warfighting,"(Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1992), 45-50. See also, Hunter, 2-1.

[3] Brennan, 18.

[4] Hunter, 2-1.

[5] Assistant Secretary of Defense for Health Affairs, Medical Readiness Strategic Plan 1995 – 2001, (Washington, DC: March, 1995), vii.

[6] Sam Nunn, "The Defense Department Must Thoroughly Overhaul the Services' Roles and Missions (Speech)," quoted in Wehrly, 2.

[7] Hunter, 6-44.

[8] Ibid, 7-3.

[9] Ibid, ES-3.

[10] Ibid, ES-5.

[11] Ibid, 6-36.

[12] Wehrly, 47.

[13] Ibid, 49.

[14] Ibid.

[15] Ibid.

[16] Ibid, 48.

[17] Ibid.

[18] Ibid, 49.

[19] Ibid.

[20] Ibid, 45-50. See also, Hunter, 2-1, 2-14.

[21] Wehrly, 49. Listed as the Cooke Study in Wehrly, I believe that Werhly is referring to the study I found published under Directorate for Organizational and Management Planning, 1991.

[22] Hunter, 2-1.

[23] Brennan, 18. See also, Hunter, 2-1.

[24] Wehrly, 49.

[25] Ibid, 45-50.

[26] Ibid, 35.

[27] Department of the Army, FM 100-5: Operations, (Washington, DC: HQDA, 1993), 2-2.

[28] Ibid.

[29] Ibid, 2-10.

[30] Ibid, 2-2,3,4,10,11. See also, Joint Pub 4.02, I-1.

[31] Joint Pub 4.02, I-6, para 6.b.

[32] Department of the Army, FM 8-10: Health Service Support in a Theater of Operations, (Washington, DC: HQDA, 1991), 2-9.

[33] Hunter, 6-10.

[34] Hunter, ES-6.

[35] John Blair, Challenges in Military Health Care, (New Jersey: Transaction Publishers, 1993), 37. DHC and how it should be handled is a vast subject that begs further study, but is beyond the scope of this paper.

[36] Wehrly, 7.

[37] Ronald Blanck, Melvin Butler, James Connolly III, "Medical Corps Peacetime Issues Affecting Wartime Readiness," (Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1986), 5.

[38] Wehrly, 8-12.

[39] Joint Pub 4-02, I-1, para 2.a.

[40] Ibid, para 2.b.

[41] Personal Memorandum for Record. From time as Division Surgeon, 3AD, during Desert Shield/Storm, 1990. Reserve MEDEVAC helicopters arrived in theater carrying radio equipment only capable of "old squelch" settings.

[42] Blair, 149.

[43] Personal Memorandum for Record from 1988-89, while serving as Chief of Anesthesia and Operative Services, Womack Army Community Hospital, Fort Bragg.

[44] Robert Claypool, “Military Medicine as an Instrument of Power: an Overview and Assessment,” (Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1989), 26, 27.

[45] Ibid, 9-17.

[46] Department of the Army, FM 8-42, (Washington, DC: HQDA, 1995), 2-6.

[47] Claypool, 32.

[48] Wehrly, 49.

[49] Ibid.

[50] FM 100-5, 2-4,5,6.

[51] Wehrly, 5.

BIBLIOGRAPHY

Blair, John, Jay Stanley. Challenges in Military Health Care. New Jersey: Transaction Publishers, 1993.

Blanck, Ronald, Melvin Butler, James Connolly III. "Medical Corps Peacetime Issues Affecting Wartime Readiness." Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1986.

Brennan, Michael. "Military Medicine for the Twenty-First Century: To Shape the Future." Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1992.
.

Buckley, Robert. "Service Uniqueness: Stumbling Block to Jointness." Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1989

Casinelli, Paul. Personal Career Notes.

Claypool, Robert. " Military Medicine as an Instrument of Power: an Overview and Assessment." Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1989.

Department of the Army. FM 8-10: Health Service Support in a Theater of Operations. Washington, DC: HQDA, 1991.

_____. FM 8-10-6: Medical Evacuation in a Theater of Operations. Washington, DC: HQDA, 1995.

_____. FM 8-10-9: Combat Health Logistics in a Theater of Operations. Washington, DC: HQDA, 1991.

_____. FM 8-42: Washington, DC: HQDA, 1995.

_____. FM 100-5: Operations. Washington, DC: HQDA, 1993.

_____. Medical Readiness Strategic Plan 1995-2001. Washington, DC: ASD-(HA), 1995.

Directorate for Organizational and Management Planning. Review of the Department of Defense Organization for Health Care. Washington, DC: Director of Administration and Management, 1991.

Hix, William and Susan Hosek. Elements of Change in Military Medical Force Structure: a White Paper. Santa Monica, CA: Rand, 1992.

Hunter, Richard. Report for the Secretary of Defense on the Feasibility and Benefits to

be Gained from Creating the Defense Health Agency. Arlington, VA: Systems Research and Applications Corporation, 1983.

Wehrly, David. "Military Medicine Focused for Joint Warfighting." Unpublished Research Paper, U.S. Army War College, Carlisle Barracks, PA: 1993.

United States Joint Chiefs of Staff. Joint Pub 4-02: Doctrine for Health Service Support in Joint Operations. Washington, DC: USGPO, 1995.

_____. Joint Pub 4-02.1: Joint Tactics, Techniques, and Procedures for Health Service Logistics Support in Joint Operations. Washington, DC: USGPO, 1997.

_____. Joint Pub 4-02.2: Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations. Washington, DC: USGPO, 1996.

Abstract of

THE JOINT MEDICAL COMMAND: BOON OR BANE FOR THE SUPPORTED CINC?

This paper argues that the key to operational medical readiness of the Department of Defense is to inaugurate a Joint USMEDCOM. This new CINCdom should be modeled after the USTRANSCOM and USSOCOM, a functional, supporting, Joint CINCdom. Arguments are presented to counter those previously used to defeat such a proposal. Indispensable to the success of such an undertaking is the requirement that the enterprise be a truly Joint endeavor, whose primary effort is to plan and train for operational (field) Health Service Support across the spectrum of the Department of Defense.